



Latinas and Maternal and Child Health: Research, Policy, and Representation

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Abstract

Over the last 50 years, the Latino population in the US has grown and changed. Latinos are the nation's largest minority group and among this group, there is incredible diversity. Much of Latino health research and outcomes have been treated interchangeably with immigrant health, but as the US Latino population evolves so should the focus of Latino health research. We contend that as maternal and child health (MCH) outcomes are an utmost important indicator of a country's health, and as Latinos make up 18% of the US's population, it is imperative that we move past dated research frameworks to a more nuanced understanding of the health of Latina women and children. We summarize how acculturation has been used to describe differences in MCH outcomes, discuss how the umbrella term "Latino" masks subgroups differences, explore Afro-Latinidad in MCH, examine the effects of the sociopolitical climate on the health of families, and demonstrate the limited representation of Latinos in MCH research. We conclude that a deeper understanding of Latino health is necessary to achieve health equity for Latina women and their children.

Keywords

Latina; Latino; Hispanic; Acculturation; Afro-Latina; Representation

Introduction

Latinos in the United States are a diverse and dynamic minority group, as well as the nation's largest, accounting for 52% of the nation's population growth in the past decade. The US Hispanic population has now reached more than 62 million, a substantial growth from 9.6 million just 50 years ago. The majority of this growth is due to US births rather

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Author Contributions CL and MM conceptualized the manuscript and all authors contributed to literature reviews, writing, and editing.

Competing interests No conflicts of interest to disclose.

Ethical Approval As this is a commentary on available literature, ethics approval were not sought.

than immigration with over 90% of Latino children as US-born citizens (Krogstad & Noe-Bustamante, 2021; Turner et al., 2016). The predominance of new births over immigration as a source of Latino population growth represents a historical reversal in trends as in the 1980s and 1990s immigration was the population driver (Krogstad & Noe-Bustamante, 2021). Much of Latino health research and outcomes have been treated interchangeably with immigrant health, but as the US Latino population changes, it is imperative that the focus of Latino health research shifts as well.

Latino health research has largely focused on the *Hispanic Health Paradox*, the term given to the phenomenon that health indicators for Latinos tend to be more favorable than their socioeconomic status would predict. In MCH specifically, research on the paradox has centered on low birthweight and infant mortality, demonstrating that infants born to Latinas are less likely to experience either of these adverse outcomes compared to white non-Latinas (Hoggatt et al., 2012; Sanchez-Vaznaugh et al., 2016). However, these findings have been largely contradicted when empirical studies extended beyond descriptive research and examined Latino subgroups (Hoggatt et al., 2012; Sanchez-Vaznaugh et al., 2016). Montoya-Williams et al. (Montoya-Williams et al., 2021) recently described the nuances of Latino perinatal health outcomes within the greater context of the Hispanic Health Paradox, demonstrating how the paradox masks the reality that Latino health status differs by nativity, country of origin, and levels of acculturation. Perreira and Allen further argue that the paradox is not universal and that immigration experiences, neighborhood context, and sociopolitical climate shape children's health and development (Perreira & Allen, 2021). These distinctions are especially important given the changing demographics of the country, high Latino birth rates, and variations within who makes up the Latino population.

We contend that as maternal and infant health outcomes are a key indicator of a country's health, and as Latinos are a diverse population that makes up 18% of the US's population, it is imperative that we move past dated research frameworks and into a deeper understanding of the health of Latinas and children. In the subsequent sections, we summarize how acculturation and cultural values have been used to describe differences in MCH outcomes, discuss how the umbrella term "Latino" masks subgroup differences, explore Afro-Latinidad in MCH, examine the effects of the sociopolitical climate on the health of families, and demonstrate the limited representation of Latinos in MCH research. We build on our review of this literature to suggest recommendations for moving MCH research forward among Latinos and conclude with the need for representation in research and decision-making positions to improve health outcomes for Latinas and their children.

Acculturation and Culture

Although definitions vary, acculturation has been broadly defined as the process by which individuals from one culture adopt the attitudes, beliefs, and behaviors of another culture (Hunt et al., 2004; Schwartz et al., 2010). Different theoretical models have attempted to explain the acculturation process (Abraído-Lanza et al., 2006; Berry, 1980; Montoya-Williams et al., 2021), demonstrating how the heritage culture and receiving culture intersect resulting in various orientations. The unidimensional model supports a linear process whereby the heritage culture is shed as individuals move towards assimilation. The

bidimensional model expands the unidimensional model by including biculturalism, or the practice of strong adherence to both cultures (Schwartz et al., 2010). The multi-dimensional model, which is the most widely accepted, posits that individuals selectively adopt practices and traits from each culture. Acculturation has been thought to affect the gradient of Latino health— as individuals become more acculturated, health outcomes may improve or worsen, depending on the health outcome itself, contextual exposure, cultural maintenance, and the willingness to adopt the receiving culture’s normative behaviors (Abraído-Lanza et al., 2016). Among Latinos, studies on acculturation have demonstrated that it may play a significant role in the risk for developing poorer physical and mental health outcomes, including obesity (Ai et al., 2018), substance use (Martinez et al., 2017; Rogers et al., 2022), cancer, cardiovascular disease (López et al., 2019), depression (Torres, 2010), and all-cause mortality (Lara et al., 2005).

In the context of MCH, numerous studies have suggested that acculturation is associated with low birth weight, premature birth, and small for gestational age among Latinas (Lara et al., 2005). Specifically, when compared to their foreign-born counterparts, U.S.-born Latinas experience higher rates of these 3 untoward birth outcomes than foreign-born Latinas (DeSisto & McDonald, 2018). Perinatal behaviors like breastfeeding are also correlated with acculturation as researchers have consistently found that the prevalence rates of breastfeeding initiation, duration, and exclusivity are significantly lower in more acculturated than less acculturated Latinas (Ahluwalia et al., 2005; Barcelona de Mendoza et al., 2016). In fact, breastfeeding rates among Latinas tend to deteriorate the longer they live in the US (Gibson-Davis & Brooks-Gunn, 2006; Harley et al., 2007; Hohl et al., 2016; Kimbro et al., 2008). This association between acculturation and lower levels of breastfeeding is particularly important given that studies have indicated that children born to more acculturated mothers may experience a disproportionate burden of disease across the lifespan (Elder et al., 2005).

Despite this evidence—inconsistent results reflect the difficulties in accurately measuring acculturation—given its dynamic, subgroup-specific, and temporal nature (Schwartz et al., 2010). Several proxies for acculturation have been used including language, country of origin, immigration status and years living in the US, each producing its own association with health status (Isasi et al., 2015; López et al., 2014). Researchers have posited suspected underlying causes of the untoward health effects of acculturation such as decreases in cultural values like family connectedness, disruption in social networks, and shifts in neighborhood patterns (Abraído-Lanza et al., 2016). One of the novel proposed determinants of the observed intergenerational decline in health among Latinos in the US is fetal programming, the concept that a maternal stimulus at a critical period in fetal development has long-term effects on the offspring (Fox et al., 2015; Liu & Glynn, 2021). Maternal acculturation may result in unfavorable fetal programming and intrauterine development. In other words, the health-related effects of acculturation that already have occurred in first-generation individuals may be transmitted to the next generation, accumulating these untoward effects. Studies on the health effects of acculturation do not account for its multidimensionality, treating acculturation solely as unidirectional movement away from the culture of origin failing to detect the health benefits of biculturalism. Bicultural identification has been associated with lower stress and anxiety in pregnancy (Barcelona

de Mendoza et al., 2016; Chasan-Taber et al., 2020); highlighting how culture can be a protective factor for MCH outcomes. As the majority of Latinos are now US-born, and as US society is increasingly influenced by Latino cultural elements such as music and cuisine, the research and understanding around acculturation has to begin to consider which cultural values from both the heritage culture and the receiving culture are adopted and retained and how those values can act as risk or protective factors for health promotion and disease prevention. Evidently, although acculturation has been widely studied, there is still much to uncover regarding its effect on maternal and child health.

The Masking Effect of the Latino Monolith

Latinos in the United States are grouped- as one ethnic identity- with little acknowledgment of varying racial dynamics, histories of colonization, and differences across Latino cultures while being united by concepts like *familismo* (the importance of family) and *respeto* (respect). However, we contend that Latinos are not a monolith and investigating them as such may be masking or minimizing risk factors and negative health outcomes. Consequently, many of the health outcome rates we share here can be contested by examining Latinos by countries of origin. For instance, in 2109, infant mortality rates between non-Latina White mothers and Latina mothers are nearly 1:1 at 4.49 and 5.03 infant death per 1000 live births, respectively (Barcelona de Mendoza et al., 2016; Chasan-Taber et al., 2020). However, when observing infant mortality rates by Latino sub-groups increased disparities emerge, where infant death per 1,000 live births are 4.14 for Cubans, 4.53 for Central and South Americans, 4.96 for Mexicans, and 6.17 for Puerto Ricans (Ely & Driscoll, 2021). Similarly, when simply comparing total Latinas (72.3%) and non-Latina white women (82.8%), first trimester prenatal care outcomes seem similar and could mask the fact that Cuban-American mothers (82.0%) receive such care at higher rates than Central & South Americans (66.4%) (Osterman et al., 2020). The same can be said for smoking during pregnancy where the overall Latina rate is 1.4% but teased out by sub-group, the rates range from 4.5% in Puerto Ricans to 0.4% in Central and South Americans (Osterman et al., 2020).

Moreover, researchers need to not only incorporate national origin subgroup identity, but also take into consideration the timing of group settlement, geographic locations, and the needs of newcomer versus established Latino origin populations (Krogstad & Noe-Bustamante, 2021). For example, the composition of established and newcomer Latino populations varies across the country and its metropolitan areas. Mexicans represent the majority of Latinos in the US (over 37 million) and comprise the majority of Latinos in California and Texas major metropolitan cities like Los Angeles and Houston. However, in the last decade, Mexicans had among the smallest increase of population growth among Latinos in the US at just 13% (Krogstad & Noe-Bustamante, 2021). In contrast, the Venezuelan-origin population in the U.S. increased 172% to 660,000, by far the fastest growth rate. As a result, ethnic origin makeup throughout the topography of the United States also varies widely among subgroups. Cubans are the majority Latinos in the Miami metro areas, Salvadorians are the largest group in Washington D.C., and Puerto Ricans and Dominicans in New York/New Jersey (Osterman et al., 2020). A great example of this is evidenced in the Hispanic Community Health Study/Study of Latinos (HCHS/SOL). The

success of the HCHS/SOL can be partly attributed to their intentional, probability sampling strategy that included targeted outreach to four communities in the Bronx, Chicago, Miami, and San Diego. Each community's field center was purposely chosen to ensure both geographic balance and Latino subgroup diversity (LaVange et al., 2010). To date, the HCHS/SOL study has recruited over 16,000 Latino adults with family roots in Cuba, Puerto Rico, Dominican Republic, Mexico, Central and South America. One of their recent studies found that women with Mexican, Puerto Rican, or Dominican heritage had the highest prevalence of self-reported gestational diabetes mellitus (9–11%) while women with Central American, Cuban, or South American heritage had a lower prevalence (4–5%) (Casagrande et al., 2022). Additionally, women with Cuban or Puerto Rican heritage and a history of gestational diabetes had significantly higher odds of incident diabetes compared with women with Mexican heritage (Casagrande et al., 2022).

Considering subgroup identity and geographic location is vital to understanding Latino MCH and the creation of targeted intervention strategies, especially among origin subgroups that are often overlooked or grouped into an epidemiological paradox, which is arguably driven by the majority of origin groups. Furthermore, among Latinos in the United States, social factors such as socio-economic status, education, living and working conditions need to be considered to gain a more nuanced understanding of Latino health, especially in MCH. Many empirical studies focus on Latinos as a whole and use them as comparison to other racial groups, most commonly Black and White populations. In doing so, factors like education or income level can be conflated with racial identity masking how these characteristics advance or diminish health within ethno-racial subgroups. Indeed, studies comparing birth outcomes among Latinas and White women have typically included limited or no information about women's socioeconomic characteristics, although evidence has linked birth outcomes with multiple socioeconomic indicators (Blumenshine et al., 2010). The results of one study looking for evidence of the Hispanic Health Paradox and assessing the possible role of socioeconomic factors in observed differences in birth outcomes demonstrated the very non-paradoxical finding that greater socioeconomic disadvantage results in poor birth outcomes for Latinas no differently than White women (Sanchez-Vaznaugh et al., 2016).

The homogenization of Latinos is in no way unique; the intragroup diversity of African Americans and Asians, for example, are similarly disregarded (Jiménez et al., 2015). However, as Jiménez et al. so eloquently point out:

“An increased focus on intra-group diversity need not take away from tracking trends and theorizing about how ethnoracial origin shapes different outcomes and life chances between groups...understanding how it matters for identity now and in the future requires maintaining a focus on the multiple consequences of within and between-group variations (p.113).”

In other words, studying inter- and intra-group differences are both important and essential endeavors in order to achieve health equity across health behaviors and outcomes.

Afro-Latinas

In maternal and child health inequities, much attention has been paid, and rightly so, to the health of Black women and children, who experience dramatic disparities in pre-and perinatal health outcomes. The maternal mortality rate for Black women is 2.9 times the rate for white women and 3 times the rate for Latinas (Hoyert, 2020). Black infants die at twice the rate of white and Latino infants (Ely & Driscoll, 2021). Determinants of these disparities include differences in maternal stress, access to care for both the mother and child, structural and interpersonal racism, and other systemic barriers (Giscombé & Lobel, 2005).

Up to now, health disparities in the US has identified ethnicity and race as mutually exclusive categories, e.g. non-Latino Black vs Latino. However, this ignores the sizeable population that classifies themselves as Latino *and* Black and Latino *and* White. *Afro-Latinas* and *Black Latinas* are interchangeable terms that refer to individuals who self-identify as Black and Latina ethnically (Tamir, 2021; Thomas, 2022). About 6 million US adults identify as Afro-Latinos (Gonzalez-Barrera, 2022). Notably, over two-thirds are of reproductive age emphasizing the importance of including this race/ethnicity group when examining health outcomes related to young adults, such as maternal and child health.

Studying Latinos as a homogenous group inherently omits Afro-Latinos' experiences and health disparities (Cuevas et al., 2016). Although, there is a paucity of Afro-Latina health research, the literature suggests that Afro-Latinas are at a health disadvantage due to the intersectionality of multiple minority identities (Cuevas et al., 2016; Thomas, 2022). Despite the idea that cultural constructs like religiosity and familismo are thought to play a role in protecting health outcomes among Latinos, the unique stressors brought on by society's unequal treatment of individuals solely on the basis of race can curtail these benefits due to interpersonal and contextual level discrimination (Cuevas et al., 2016).

Recently, Thomas (Thomas, 2022) explored the role of "street-race", phenotype and colorism, in pregnancy and birthing experiences. The results of that study point to the negative reception that Afro-Latinas face at the clinical encounter, and how, regardless of the conflation between race and ethnicity, phenotype creates similar, shared experiences of anti-Black racism for Afro-Latinas. That is to say that Afro-Latinas reported being treated differently than their white-presenting counterparts and discussed how it impacted their maternal health care. Research indicates that maternal experiences that predate conception influence birth outcomes (Collins et al., 2004; Dixon et al., 2012). There is evidence for low birth weight in infants being significantly higher for Black Latinas than their White Latina counterparts (Mydam et al., 2019). However, there have been inconsistent results when examining differences in infant mortality in Latinos by race (Galan et al., 2022; Rice et al., 2017). Still, it is unknown if multiracial women such as Afro-Latinas experience adverse birth outcomes at an even higher prevalence. The extent to which birth outcomes are influenced by a woman's identity as a Black Latina, including the consequences of institutionalized, interpersonal, and internalized racism that may accompany that identity, has received very little attention (Mydam et al., 2019).

Sociopolitical Consequences

It is important that while we unpack the lack of nuance afforded to Latino health outcomes, we also acknowledge the sociopolitical context that has shaped maternal and child health for Latinas in the US. For example, although the vast majority of Latino children are US-born, more than half have at least one immigrant parent, some of whom are unauthorized to reside in the US (Child FIFo, 2017). The immigration experience is fraught with injustices spanning family separation at the border to reproductive sterilization in state institutions and detention centers to anti-immigration policies and practices. Family separations at the US-Mexico border are nothing new, but the implementation of the 2018 Zero Tolerance Policy amplified this traumatizing practice, separating an unknown amount of parents from children even as young as infants (estimated at 2737 children) (Peña et al., 2019). Prior research has shown that children who were separated from their parents as a result of migration are at an increased risk of anxiety, depression, and psychotic disorders. Adopting these restrictive immigration policies often results in prolonged detention. In detention centers, women and children are particularly vulnerable to violence and abuse (Dudley et al., 2012). In one recent example, news broke in 2020 that in the Irwin County Detention Center in Georgia detained migrant women were being misled and coerced into forced sterilization (Davis, 2022). The US has a long abhorrent history of reproductive injustices that includes California's eugenic sterilization laws which biased against Mexicans describing them as "immigrants of an undesirable type" (Novak et al., 2018). In Puerto Rico, women were used in sometimes dangerous clinical trials to test birth control pills and the Depo Provera contraceptive shot often without knowledge or consent and were targeted in efforts to remedy "overpopulation" of the island through family planning which resulted in the highest rate of female sterilization in the world (Gutiérrez & Fuentes, 2009).

Anti-immigrant policies and practices have been linked to poorer maternal and child health outcomes among all Latinos and illustrate the stressors that occur when divisive policies are so closely conflated with an ethno-racial group. For example, after a federal immigration raid in an Iowa meat-processing plant, one study found a greater risk of low birth weight among children born to Latina mothers compared with births the year before the raid; no such change appeared among births to non-Latina women (Novak et al., 2017). In another instance, Arizona Senate Bill 1070 (SB1070) empowered police to detain individuals who were not able to prove their citizenship on request (Hardy et al., 2012). Research showed that this policy increased fear among Latinos because of racial profiling and harassment from authorities within their community (Hardy et al., 2012). Prenatal exposure to SB1070 coincided with lower birth weight among children born to Latina immigrant women but not among children born to US-born white, black, or Latina women (Torche & Sirois, 2019).

The examples presented here demonstrate how restrictive policies and practices can shape health outcomes for Latinos, but it is important to acknowledge that anti-immigrant rhetoric also can facilitate racism and xenophobic attitudes toward all Latinos, irrespective of immigration status, creating fear and effecting the way Latinos interact with systems meant to assist. For example, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) reports that since 2017, WIC clinics across the country saw a heightened level of fear among immigrant and mixed-status families prompting eligible

families to refuse access to vital nutrition and breastfeeding support. Latino coverage rate declined nationally by 10% and clinics in high-immigrant communities reported at least a 20% decline in their caseload; this even with WIC's eligibility not limited on the basis of citizenship or immigration status. The disenrollment of this safety net program is not without basis. In 2018, the federal government proposed changes to a longstanding statute that bars individuals likely to become a public charge: a person who primarily depends on the government for subsistence (Bleich & Fleischhacker, 2019). Historically, dependence on government assistance narrowly included participation in cash assistance or long-term institutionalized care. The proposal expanded the list to include SNAP, *Temporary Assistance for Needy Families* (also known as welfare), Medicaid, Medicare Part D (also known as prescription drug subsidies), and (Bleich & Fleischhacker, 2019) (also known as housing vouchers). Essentially, participation in these programs would deny a path to citizenship if immigrants (lawfully present or not) had participated in certain federal safety net programs. In 2019, the more expansive public charge rule was enacted producing a "chilling effect" that led many immigrant families, including citizen children in these families, to not seek assistance including health coverage and care for which they were eligible (Artiga, 2022). Here we weave together historical context and recent incidents to demonstrate how US systems are weaponized against Latinos and as we continue to battle for reproductive justice, these cases are uniquely informative in how systemic discrimination and oppression are upstream causes of poor maternal and child health.

Representation of Latinas in MCH Research and Practice

If Latino health understanding is to evolve to meet the dynamic nature of this population in the US, then so too should the development of health researchers in academia, medicine, and science evolve to empower diversity and representation at every level. That is to say that racial/ethnic health disparities persist, and in order to address them, health practitioners, scientists and study participants must be representative of the larger population. Inclusive participation in biomedical and clinical trials benefits scientific discovery, and while strides have been made to diversify enrollment in health research, historically, clinical trials and cohort studies simply do not include enough participants from the racial/ethnic groups that are disproportionately affected to extrapolate any conclusions about their treatment (Oh et al., 2015; Rubin, 2021; Sharma & Palaniappan, 2021). The underrepresentation of racial/ethnic minority research participants is true among trials in vaccines (Flores et al., 2021), cancer (Loree et al., 2019), cardiovascular disease (Sardar et al., 2014), and diabetes (Akturk et al., 2021). A review of published literature related to gestational weight gain found that 72% of studies included White women while only 66% included Black women, 45% included Latinas, and 20% included Asian women (Denize et al., 2018). An analysis of 142 NIH-funded randomized controlled trials found that Latino enrollment was not reported in over half of the studies (Geller et al., 2018). There are several possible reasons for this lack of representation in research studies including fears of exploitation, competing demands of time, and financial constraints (Oh et al., 2015). Montoya-Williams et al. (2021) (Montoya-Williams et al., 2021) wisely point out that research among Latinas poses the challenge of data collection among socially and politically vulnerable women who may be hesitant to participate because of a language barrier and documentation status. The editors of the *New England Journal of Medicine* also contend that "another major contributor is the dearth

of investigators and study staff who are themselves members of minority groups.”(Rubin, 2021).

Lack of representation in the public health workforce is due in part to disparities in and threats towards educational attainment among Latinos in the U.S. Latino students maintained the highest high school dropout rates at 7.4% compared to Asian students (2.4%), Black students (4.2%), and White students (4.8%) (Statistics. NCfE, 2020). In turn, studies show Black and Brown students are subject to increased levels of school push out, or the decision to leave school due to various social and institutional factors, and early criminalization than their non-minoritized counterparts (Luna & Revilla, 2013; Mireles-Rios et al., 2020; Schneider et al., 2006). Despite such challenges, the graduation gap between Latino and non-Latino students has been narrowing over the last 50 years and greater numbers of Latinos have begun to pursue higher education (Fry & Taylor, 2013). In fact, more Latinos are entering 2 and 4-year institutions than ever before (Quintana, 2020), and between 2009 and 2019, Latino student college enrollment increased by almost 50 percent to 3.5 million students (Osterman et al., 2020). Yet, the lack of diversity and representation are still evident in higher education. As an example, just 8.1% of doctoral degrees conferred at programs of public health were to Latinos (Goodman et al., 2020). Barriers to Latino education persist due to disparities in family financial abilities, programs that support first-generation college student retention, and lack of access to financial aid among non-citizen students (Osterman et al., 2020). Therefore, ongoing support for this burgeoning group of scholars, practitioners, and researchers is more vital than ever.

It is important to consider who is in our classrooms and who holds leadership roles, and opportunities for advancement among the Latino labor force, especially in public health. For instance, according to Ramirez-Valles, Neubauer, and Zembrana (The Growing Hispanic Demographic & the Workplace, 2021) of the 10,326 public health faculty in the U.S.; only 4% are Latino and when looking at ranks of professors this share continues to decrease: Latinos make up 4.8 and 4.9% respectively of assistant and associate professors, but only 3.1% of full professors. This lack of representation is seen across academia. Latinos represent a mere 3.2% of faculty in Medicine, and only 5.1% of faculty across all universities (The Growing Hispanic Demographic & the Workplace, 2016). As Ramirez-Valles, Neubauer and Zambrana (The Growing Hispanic Demographic & the Workplace, 2016) rightly point out -

“Education is richer when classrooms, textbooks, and laboratories represent the diversity of our society, and health organizations and programs can be more effective than what they are now when their workforce is diverse and able to create and sustain community engagement.”

Furthermore, Latinos represent only 5.4% of the NIH principal investigator pool (Ramirez-Valles et al., 2022) and 6.2% of reviewers for the NIH Center for Scientific Review (Health NIO., 2021). Odedina and Stern discuss that while academic and scientific institutions have recently begun to address the problems of diversity, equity, and inclusion (DEI) in science and academics, there are fraught issues in extramural funding in science and medicine (Review NCfS., 2022). These issues include a lack of diversity in reviewers which may bias funding for health disparities researchers who are often from under-represented

minority groups addressing the needs of their own communities; the growing threat to the funding of under-represented minority scientists due to the attraction of already successfully funded non-minority scientists to health equity research *because* of the burgeoning funding opportunities; undervaluing research coming out of minority-serving institutions; and the “Diversity Tax” whereby a small number of scientists are tasked with DEI committee assignments taking time away from their research (Review NCfS., 2022).

While it is true that strides need to be made in DEI, it is important that we, the five Latina authors, acknowledge the public health research pioneers who have advanced the field of Latino MCH through advocacy, education, and inclusive metrics and intervention strategies reflective of Latinos and other minoritized communities. Dr. Helen Rodríguez-Trías’s revolutionary work called attention to the forced sterilization of Puerto Rican women, advocated for HIV-infected women, and enhanced women’s reproductive rights and well-being worldwide by combining her formal training and expertise with the lived experiences of herself and her family. Her legacy endures as the first Latina to serve as president of the American Public Health Association (APHA) and has merited one of the highest honors in the APHA with an award named for her which honors those who do extraordinary work toward social justice for underserved and disadvantaged populations since 2005 (Odedina & Stern, 2021). Dr. Gortran Lamberty, Director of Research at the Maternal and Child Health Bureau in the 1980 and 1990s, advocated for a better understanding of child development in minority populations and published *Puerto Rican Women and Children: Issues in Health, Growth, and Development* (Association, 2022). Dr. José F. Cordero was the founding director of the National Center for Birth Defects and Developmental Disabilities (NCBDDD) at CDC, which became the leading international institution devoted to research and prevention of birth defects and developmental disabilities and health promotion of people of all ages living with disabilities. Dr. Edna Viruell- Fuentes shone a light on structural racism pushing researchers to move away from individual level explanations for racial and ethnic health disparities and into socio-cultural explanations (Lamberty & Coll, 1994; Viruell-Fuentes, 2012). Other prominent leaders are Dr. Rafael Pérez-Escamilla, an international leading expert and advocate for breastfeeding; Dr. Barbara Ferrer, currently the Chief Public Health Officer of Los Angeles County; Dr. Margarita Alegria, a trailblazer in mental health and mental health care in US Latinos; and Dr. Claire Brindis, a pioneer in health services research and the first Latina to be awarded the Martha May Elliot award, honoring extraordinary health services to mothers and children.

In recent years the NIH has undertaken a concerted effort to promote the diversity of the scientific workforce, appointing its first Chief Officer of Scientific Workforce Diversity in 2014. Initiatives include the “Broadening Experiences in Scientific Training” (BEST) awards for institutions to broaden opportunities for graduate and postdoctoral training, targeted “diversity” grant-funding opportunities for doctoral students and early-stage investigators, and importantly, efforts to assess the impact of NIH diversity initiatives for reducing the funding disparities. Fittingly, the National Institute on Minority Health and Health Disparities, led since 2015 by Eliseo Perez-Stable, is a leader in the NIH’s efforts to promote the career development of early-stage investigators from groups underrepresented in science with research center programs including the Research Centers in Minority Institutions (RCMI) aimed at strengthening the research infrastructure at

minority-serving academic institutions, and the Specialized Centers of Excellence (COE) and Centers of Excellence on Environmental Health Disparities Research (EHD), which include investigator development cores that provide career development opportunities through pilot funding and research training. NIMHD research centers focused predominantly on Latino health include RCMI's at the University of Texas at El Paso, University of California Riverside, Ponce School of Medicine, and San Diego State University; COE's at the University of Miami/Florida International University, Arizona State University, and University of New Mexico; and the EHD at the University of Southern California, MADRES, focused on maternal and child health. Increased networking among these centers, and other NIH centers focused on Latino health, could further strengthen the training and career development of Latino scholars.

We call for more attention to increasing representation among Latinos in science, medicine, and across the academy. We also extend this call to be inclusive of the creation of pipelines for the burgeoning group of Latino undergraduate students, the development of pipelines for Latinos in management and leadership positions, and the representation of Latinos in the public health workforce. Simply put, diversity drives excellence. As Goodman et al. (2020) argue, "to address racial/ethnic disparities in health outcomes, it is important to have a racially and ethnically diverse workforce that is capable of addressing such public health issues" (p. 74) (Goodman et al., 2020). Diverse thinkers impact health inequity by allowing their work to be impacted by their unique lived experiences and using their community's shared culture to help inform solutions.

Conclusions

Emerging science has demonstrated the nuances in Latino health research and how acculturation, nativity, nationality, socioeconomic status, racism, and immigration policies and practices explain differences in health behaviors and health outcomes. It is imperative that we move away from dated Latino health frameworks and learn more about the complexities of influences on Latino health. Improving the health of mothers and children is crucial as their well-being determines the health of the next generation. Through a deeper understanding of Latino health, we may be able to achieve better health equity, justice, and improved health outcomes for Latino MCH and Latino health in general.

Funding

This work was supported by an award to Cynthia Lebron by the National Heart Lungs and Blood Institute (K01 HL160915-01A1) and by the Center for Latino Health Research Opportunities (CLaRO; 3U54MD002266-15S2).

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Significance

What is already known on the subject?

The Hispanic Health Paradox, the phenomenon that Latinos have better health outcomes than their socioeconomic status would predict, breaks down when empirical studies extended beyond descriptive research and examined Latino subgroups. Substantial heterogeneity within Latinos is observed in health outcomes, especially in maternal and child health.

What this article adds to the literature?

We provide a comprehensive demonstration of the varied determinants of maternal and child health in Latinas such as acculturation, the Latino monolith, race, policies, and representation.